Unannounced Medicines Management Inspection Report
20 June 2016

Ard Mhacha House Care Centre

Type of Service: Nursing Home
Address: Desart Lane South, Armagh, BT61 8AR
Tel No: 028 3752 6462
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Ard Mhacha House Care Centre took place on 20 June 2016 from 09.25 to 14.25. The Bard, Cathedral and Orchard units were inspected.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The management of medicines supported the delivery of safe care. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Appropriate arrangements were in place for the management of pain. One recommendation was made regarding the management of thickening agents.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term ‘patients’ will be used to described those living in Ard Mhacha House Care Centre which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**1**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Norma McAllister, Registered Manager and Ms Tina Chapman, Regional Director, Countrywide Care Homes Limited as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent estates inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 12 April 2016.

2.0 Service details

Registered organisation/registered provider: Countrywide Care Homes (4) Limited/ Mrs Victoria Craddock	**Registered manager:** Mrs Norma McAllister
Person in charge of the home at the time of inspection: Mrs Norma McAllister	**Date manager registered:** 23 October 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), RC-DE	**Number of registered places:** 74

3.0 Methods/processes

Prior to inspection, the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

During the inspection, the inspector met with three patients, the registered manager, two registered nurses, one team leader and one senior care assistant.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 April 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 9 February 2016

There were no requirements or recommendations made as a result of the last medicines management inspection.

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in general medicines management was provided within the last year.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration records were updated by two staff. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs, which is good practice.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturers' instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. A couple of discrepancies were noted in liquid medicines. The registered manager gave an assurance that she would increase the audits on liquid medicines to ensure they were being administered in accordance with the prescribed dosage instructions.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly and three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the parameters for administration were recorded on the personal medication record. A care plan was maintained. The reason for and outcome of administration had been recorded. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment was completed as part of the admission process. A pain assessment tool was completed and updated as necessary. A care plan was maintained and it was evaluated on a monthly basis. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

The management of swallowing difficulty was examined. Care plans were in place. For those patients prescribed a thickening agent, this was not consistently recorded on their personal medication record (including details of the prescribed fluid consistency). Administrations were not usually recorded. A recommendation was made.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Medicine records were maintained in a satisfactory manner and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for opioid transdermal patches and warfarin. For several eye preparations, the route of application was not recorded on the personal medication records; the registered manager gave an assurance that this would be rectified. The registered manager also gave an assurance that obsolete personal medication record sheets would be removed from the medicines files.

Practices for the management of medicines were audited on an ongoing basis. This included running stock balances for many of the solid dosage medicines not contained in the monitored dosage system blister packs. Staff in each unit completed a medication audit each week and reported the outcomes to management. Management conducted a monthly audit. Management met with staff on each week day and any issues pertaining to the management of medicines were highlighted and discussed. In addition, a quarterly audit was completed by the community pharmacist. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice.

Following discussion with staff and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

Robust arrangements should be in place for the management of records for patients prescribed thickening agents; records should be fully maintained. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines to several patients was observed during the inspection. Medicines were administered to patients in the dining room or in their room. The member of staff administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

The patients spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were knowledgeable of the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Norma McAllister, Registered Manager and Ms Tina Chapman, Regional Director, Countrywide Care Homes Limited as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises, RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for review by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 20 July 2016	The registered provider should ensure that robust arrangements are in place for the management of records for patients prescribed thickening agents; records should be fully maintained.
	Response by registered provider detailing the actions taken: Record of Thickening Drinks was implemented on the 21st June. Copy of the record format was sent through to the Inspector on the 21st June. Records are being monitored and signed off by the Manager weekly.

The Regulation and Quality Improvement Authority

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